Nurture Psychiatry & Psychotherapy
Sheela Masifi, MD, MS

EMAIL AUTHORIZATION FORM

I hereby request that Sheela Masifi, MD, MS, communicate with me regarding my treatment via electronic mail, or e-mail.

I understand that this means Dr. Masifi will transmit my protected health information, such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment, via e-mail. I understand there are risks inherent in the electronic transmission of information by e-mail, and that such correspondence may be lost, delayed, intercepted, corrupted, altered, rendered incomplete or undelivered. I further understand that any protected health information transmitted via e-mail pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error- free and its confidentiality may be vulnerable to access by unauthorized third parties, Dr. Masifi shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the e-mail of information by Dr. Masifi to me.

After being provided notice of the risks inherent in use of e-mail to transmit protected health information, I hereby expressly authorize Dr. Masifi to communicate via e- mail with me, which will include the electronic transmission of my protected health information. I understand that this E-mail Authorization will remain in effect until I revoke it by submitting notice to Dr. Masifi in writing.

I hereby authorize the transmission of my protected health information via e-mail as described above.

Patient Signature

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Full Name (Printed)

_____

Date

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